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ABSTRACT

Although the occurrence of medical illnesses in psychiatric patients is quite high, medical illnesses manifested by psychiatric symptoms are often overlooked. The higher mortality rates among psychiatric patients when compared to the general population may be a reflection of neglect or inadequate treatment of the psychiatric patients' medical problems. Since visits by psychiatric patients to community mental health centers (CMHCs) are usually more frequent than their visits to medical clinics, it becomes a responsibility of CMHCs to monitor their patients' physical problems and to develop effective community treatment plans. To further examine this issue, all active cases of schizophrenia (N=358) and neurosis (N=69) under care at the Johns Hopkins Hospital CMHC were reviewed. Patients' physical problems recorded on their admissions charts over the past 15 years were analyzed and operationally divided into major and minor physical diagnosis. The results revealed a significant difference between groups with respect to reported physical problems, as 38% of schizophrenics and 53% of neurotics had a physical problem recorded on their admission forms. Although a significantly higher proportion of neurotic patients reported physical problems, when problems were categorized by severity, the physical diagnoses reported by schizophrenics were significantly higher in the major category. For schizophrenic patients, issues such as coordination of care, drug interactions, medicinal side effects, and patient compliance must be considered carefully. (NB)

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CONCURRENT MEDICAL AND PSYCHIATRIC DISORDERS AMONG SCHIZOPHRENIC AND NEUROTIC OUTPATIENTS

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INTRODUCTION

This paper summarizes some conceptual issues related to the interface between mental health and primary care , and presents preliminary data on the medical problems of an outpatient psychiatric population, as recorded on their charts on admission.

An association between medical illness and psychiatric illness has long been established (5,7,13,16,17,20,24) although with varying rates of frequency (4). However, it is clear that the occurrence of medical illnesses in psychiatric patients is quite high and cannot be overlooked. Researchers have also noted that a thorough medical examination and laboratory investigation of psychiatric patients result in identifying previously unsuspected and undiagnosed medical problems (11), and that medical illnesses that are manifested by psychiatric symptoms are often overlooked (10,23). Viewed in the light of these observations, the higher mortality rates among psychiatric patients when compared to general population (2,21), may be a reflection of neglect or inadequate treatment of the psychiatric patients' medical problems.

A majority of the studies in this area, however, have concentrated on inpatient psychiatric populations or outpatient psychiatric clinics, and reports on psychiatric and medical comorbidity in community mental health centers (CMHC) populations are very few. As an example, the "1986 Client/Patient Sample Survey for Outpatient Programs" forms of the National Institute of Mental Health collects information on psychiatric diagnoses

only, without any attention being paid to associated medical problems. However, such problems are likely to be at least as severe among these ambulatory CMHC patients, in whose care, because of the expanding role of non-medical therapists, the psychiatrist has less direct participation (2). This lack of physician involvement is of particular concern for at least four reasons. Firstly, psychiatric patients in general are at a higher risk of ignoring their own health care, and of being unreliable, or noncompliant with treatment (28, 29). Secondly, patients in CMHCs tend to be drawn from poorer populations, are more likely to suffer from multiple and more severe physical illnesses and disabilities, and have less access to adequate medical resources (27). Thirdly, non-medical therapists in CMHCs often practice in free-standing centers, have limited knowledge of medical issues, and have sporadic psychiatrist and physician input (9). Lastly, the deinstitutionalization movement has shifted the "locus" of care of the chronically mentally ill to outpatient and community settings, where long-term treatment is being provided for growing numbers of patients who are getting increasingly older and are more likely to have concurrent chronic medical illnesses (18).

Since visits by psychiatric patients to CMHCs are usually much more frequent than their visits to medical clinics (19), it becomes a "de facto" responsibility of CMHCs to monitor their patients' physical problems and to develop effective community treatment plans (25), including the management of patients'

medical needs, assertively ensuring they have prompt access to adequate medical care. CMHCs therefore must interface not only with social services agencies which may assist in rehabilitation of their patients, but also with the general health sector, particularly with the primary care sector that will be mostly responsible for following-up the medical needs of this population (26).

As a reflection of these concerns, this paper presents the initial assessment of the frequency of reported medical problems in two diagnostic groups of CMHC patients that represent two different levels of psychiatric severity i.e., schizophrenic and neurotic patients.

METHOD

The sample consists of all the active cases of schizophrenia (N=358) and neurosis (N=69) under care at the JHH-CMHC.

The information recorded on the charts of all these patients at the time of their admission to the JHH-CMHC over the past 15 years was retrieved to analyze their socio-demographic background and their reported physical problems and psychiatric diagnosis.

The reported physical problems were operationally divided into major and minor physical diagnosis. Any condition regarded as being liable to threaten or shorten life represented a major diagnosis; all other diagnoses were considered minor (8).

RESULTS

Patients' socio-demographic characteristics indicate a very high proportion of schizophenic patients when compared to neurotics in the JHH-CMHC, with 358 schizophrenics and 69 neurotics (Table 1). The age distribution is the same for both study groups, half being in the 26-45 age group. The sex distribution is significantly different for the two groups with a male to female ratio of 1:1 among schizophrenics and 1:4 among neurotics. About eighty percent of the subjects in both groups are black. Interestingly, similar educational levels are noted for both groups, as two-thirds have education between grades 9 and 12. The distribution of their marital status is also similar, with a slightly higher proportion of single patients among the schizophrenics.

There is a significant difference in these two groups with respect to reported physical problems, as thirty eight percent of the schizophrenics and fifty-three percent of the neurotics had a physical problem recorded on the admission form (Table 2).

The distribution of the reported physical problems into major and minor physical diagnoses (Table 3) shows that there is a substantial difference between the diagnoses classified as major (e.g., hypertension and diabetes) and minor (e.g., dental problems) with significant implications for health care delivery. Although a significantly higher proportion of neurotic patients tend to report on their physical problems, when these are categorized by level of severity, the physical diagnoses reported

by the schizophrenic group are significantly higher in the major category (Table 4).

DISCUSSION

It is apparent from the descriptive data presented here that there is a high proportion of schizophrenics among the patients in our CMHC who have socio-demographic characteristics similar to the neurotic group, with the exception of a higher proportion of females among the latter.

It is also clear that nearly half of both the schizophrenic and neurotic groups have reported medical problems, which is similar to the rates previously reported (5). There is however a clear reversal of the severity of reported physical problems among neurotic and schizophrenic patients: while neurotic patients report more physical problems in general, schizophrenics report more serious medical disorders. These recorded diagnoses need to undergo subsequent validation, but based on our experience with schizophrenic patients (3) when these patients are examined we are likely to find more medical problems rather than less, as chronically mentally ill patients tend to significantly under-report their problems.

Therefore this finding underscores at least two important issues. Firstly, the psychiatric treatment of schizophrenic patients relies heavily on psychotropic medication, which is known to have significant side effects. In addition, their medical treatment is also likely to involve additional medica-

tions. Hence, issues related to coordination of care, drug-interactions and disabling or life-threatening compounded side-effects are quite prominent.

Secondly, since schizophrenic patients tend to be poor compliers with treatment recommendations, not to follow through with referrals made and to be have inadequate social skills, they are at a higher risk for falling through the cracks. Neurotic patients, on the other hand, tend to be more preoccupied with their physical problems and to be more socially functional, and as such may utilize health services more often than emotionally normal controls, where they present multiple, less serious somatic complaints (12). It may be possible therefore that non-medical therapists, lacking the necessary knowledge base to discriminate needs for care on the basis of actual severity of the problems presented, may respond to their patients' personality traits and illness behaviors, and spend their limited resources in coordinating the management of the physical problems of the neurotic population, to the neglect of the more severely affected chronically mentally ill.

* * * * * *

In summary, we have pointed out that the relationship between CMHC and primary care clinics, formerly unidirectional, has become bilateral with the realization that not only are mental health problems frequent among primary care patients but that physical disorders are frequent and important among CMHC patients, and likely to increase as the population of the

chronically mentally ill ages. CMHCs are ill-equipped to handle this new psychiatric comorbidity. The urgent task is to design effective strategies to provide services to meet patients' total health care needs within the constraints of current practice. The dual administrative hierarchy of mental health and primary health services is a significant impediment to attain this goal, and we are now exploring various possibilities for bringing them together at the outpatient level of care. Strategies will include the establishment of a closer liaison with medical clinics and private practitioners in our catchment area; having a nurse practitioner integrated in our mental health team to provide primary medical care to selected patients (22); and training the non-medical therapists in basic screening techniques to identify physical problems of their patients, which will enable them to recognize and refer patients with physical problems and to interface with medical doctors for the necessary coordination of care, a model akin to what has been proposed for the training of general medical providers in basic psychiatric and psychosocial problems (6,14,15).

REFERENCES

1. Babigian, H.M., Odoroff, C.L. The mortality experience of a population with psychiatric illness. American Journal of Psychiatry 1969 126: 470-480.

2. Berlin, R.M., Kales, J.D., Humphrey, F.J. et al. The patient care crisis in community mental health centers: a need for more psychiatric involvement. American Journal of Psychiatry 1981, 138, 451-454.

3. Breakey, W.R., Lima, B.R., Brooks, M. et al. Varied Health Care Needs of the Mentally Ill. Panel presented at the Annual Meeting of the National Council of Community Mental Health Centers, Washington, D.C., April 10-13, 1985.

4. Bunce, D.F.M., Jones, L.R., Badger, L.W. et al Medical Illness in psychiatric patients: barriers to diagnosis and treatment. Southern Medical Journal 1982 75:941-944.

5. Burke, A.W. Physical disorder among day hospital patients. British Journal of Psychiatry 1978 133:22-27.

6. Burns, B.J., Scott, J.E., Burke, J.D., et al. Mental health training of primary care residents: a review of recent literature. General Hospital Psychiatry, 1983, 5, 157-169.

7. Davies, D.W. Physical illness in psychiatric outpatients. British Journal of Psychiatry 1965 111:27-33.

8. Eastwood, M.R. and Trevelyan, M.H. Relationship between physical and psychiatric disorder. Psychological Medicine 1972 2:363-372.

9. Fink, P.S. and Weinstein, S.P. Whatever happened to Psychiatry? The deprofessionalization of community mental health centers. American Journal of Psychiatry 1979 136:406-409.

10. Hall, R.C.W., Gardner, E.R., Stickney, S.K. al et Physical illness manifesting as psychiatric disease. II. Analysis of a state hospital inpatient population. Archives of General Psychiatry 1980 37:989-995.

11. Hall, R.C.W., Gardner, E.R., Popkin, M.K. et al Unrecognized physical illness prompting psychiatric admission: a prospective study. American Journal of Psychiatry 1981 138:629-635.

12. Hankin, J.R., Steinwachs, D.M, Regier, D.A. et al Use of general medical services by persons with mental disorders. Archieves of General Psychiatry 1982 39: 225-231. Herridge, C.F. Physical disorders in psychiatric illness: a study of 209 consecutive admissions. Lancet 1960 2:949-951.

13. Hirschowitz, R.G. Psychiatric education for non-psychiatric physicans. Archives of General Psychiatry 1972 27: 833-838.

14. Jones, L.R., Knopke, H.J., Parlour, et al. A curriculum for the psychiatric training of family physician. General Hospital Psychiatry 1981 3: 189-198.

15. Koranyi, E.K. Physical health and illness in a psychiatric outpatient department population. Canadian Psychiatric Association Journal 1972 17:SS109-116.

16. Koranyi, E.K. Somatic illness in psychiatric patients. Psychosomatics 1980 21:887-891.

17. Kramer, M. The rising pandemic of mental disorders and associated chronic diseases and disabilities. Acta Psychiatrica Scandavica, 1980 Suppl. 285, 62:383-397.

18. Lima, B.R. and Brooks, M.L. Coordination of services for outpatients under concurrent medical and psychiatric care. General Hospital Psychiatry 1985 7:330-333.

19. Marshall, H. Incidence of physical disorders among psychiatric inpatients. British Medical Journal 1949 2:468-470.

20. Martin, R.L., Gloninger, C.R., Gaze, S.B. et al. Mortality in a follow-up of 500 psychiatric outpatients. Archives of General Psychiatry 1985 42:47-66.

22. Martinez, H.L., Langrod, J. The new member of the mental health team: the physician assistant. Paper presented at the American National Council of Community Mental Health Centers, Washington, D.C., April 10-13, 1985.

23. Oppenheim, G. Physical illness diagnosed as psychiatric - patients at special risk. General Hospital Psychiatry 1982 4:241-243.

24. Phillips, R.D. Physical disorders in 164 consecutive admission to a mental hospital. British Medical Journal 1937 2:363-366.

25. Test, M.A. Effective community treatment of the chronically mentally ill: What is necessary? Journal of Social Issues 1981 37:71-86.

26. U.S. Department of Health and Human Services Toward a National Plan for the Chronically Mentally Ill. Washington, D.C. Government Printing Office, 1980.

27. U.S. Department of Health and Human Services Health Characteristics According to Family and Personal Income. Vital and Health Statistics, Series 10, No. 147, Washington, D.C. Government Printing Office, 1985.

28. Van Putten, T. Why do schizophrenic patients refuse to take their drugs? Archives of General Psychiatry 1974 31: 67-72.

29. Willcox, D.R.C. et al. Do psychiatric outpatients take their drugs? British Medical Journal 1965 2: 790-792.

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1986 CLIENT/PATIENT SAMPLE SURVEY

OUTPATIENT PROGRAMS

PSYCHIATRIC DIAGNOSIS AT TIME OF THIS REPORT

LIST THE CURRENT PRINCIPAL DIAGNOSIS AT TIME OF REPORT.

USE DSM-III (AXIS I) - AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS OR ICD-9-CM - THE INTERNATIONAL CLASSIFICATION OF DISEASES, NINTH REVISION, CLINICAL MODIFICATION TO REPORT THE DIAGNOSIS NAME AND ITS ACCOMPANYING CODE. IF THESE MANUALS ARE NOT AVAILABLE IN YOUR ORGANIZATION, PLEASE REPORT BY DIAGNOSIS NAME ONLY.

IN DSM-III, IF AXIS I IS DIAGNOSIS DEFERRED (799.90), NO DIAGNOSIS (V71.0[illegible] A "V" CODE, OR A BLANK, THEN THE AXIS II DIAGNOSIS SHOULD BE REPORTED, IF AVAILABLE.

DIAGNOSIS NAME:

_____

DIAGNOSIS CODE:

___ ___ ___ . ___ ___

CODE USED: (CIRCLE ONE)

1. DSM-III CODE
2. ICD-9-CM CODE
3. DSM-II CODE
4. OTHER (SPECIFY):

TABLE 1: SOCIO-DEMOGRAPHIC CHARACTERISTICS OF SCHIZOPHRENIC AND NEUROTIC PATIENTS

SOCIO-DEMOGRAPHIC VARIABLE		SCHIZOPHRENICS N=358		NEUROTICS N=69		
		N	%	N	%	
AGE	≤ 25	51	14.2	13	18.8	
	26-45	202	56.4	33	47.8	N.S.
	46+ ABOVE	105	29.3	23	33.3	
SEX	MALE	194	54.2	14	20.3	P <.005*
	FEMALE	164	45.8	55	79.7	
RACE	BLACK	308	86.0	54	78.3	
	WHITE	48	13.4	13	18.8	N.S.
	OTHER	2	0.5	2	2.9	
EDUCATION	≤ 8	85	23.7	15	21.7	
	9-12	235	65.6	47	68.1	N.S.
	13+	38	10.6	7	10.1	
MARITAL STATUS	SINGLE	227	63.4	35	50.7	
	MARRIED	20	5.6	6	8.7	N.S.
	WIDOW	23	6.4	6	8.7	
	DIVORCED/ SEPARATED	88	24.6	22	31.9	

* $X^2 = 26.58$, DF = 1

TABLE 2: REPORTED PHYSICAL PROBLEMS AMONG SCHIZOPHRENIC AND NEUROTIC PATIENTS

REPORTED PHYSICAL ILLNESS	SCHIZOPHRENICS NO.	%	NEUROTICS NO.	%
REPORTED	137	38.3	37	53.6
NOT REPORTED	221	61.7	32	46.4
	358	100.0	69	100.0

$X^2 = 5.6718$, D.F. 1, $P < 0.02$

TABLE 3: DISTRIBUTION OF SCHIZOPHRENIC AND NEUROTIC PATIENTS BY REPORTED PHYSICAL DIAGNOSIS

MAJOR PHYSICAL DIAGNOSIS	SCHIZO-PHRENIC	NEUROTIC	MINOR PHYSICAL DIAGNOSIS	SCHIZO-PHRENIC	NEUROTIC
HYPERTENSION	35	11	HYSTERECTOMY, S/P	3	2
DIABETES	19	6	ARTHRITIS	3	1
OBESITY	13	3	THYROID	2	3
SEIZURES	8	0	TUBERCULOSIS	2	0
ORTHOPEDIC INJURY	7	0	FIBROID TUMOR	2	0
ASTHMA/ BRONCHITIS	13	0	MENSTRUAL DIFFICULTIES	2	1
PEPTIC ULCER	5	0	HEADACHE	2	3
CANCER	2	1	DEVIATED SEPTUM	1	0
GLAUCOMA	2	1	DENTAL PROBLEM	1	0
HEART DISEASE	3	3	HEARING DEFICIT	1	1
PANCREATITIS	2	0	SPASTIC DISORDER	1	0
OBSTRUCTIVE SLEEP APNEA	1	0	POST-TUBAL LIGATION	1	0
BRAIN METASTATIS	1	0	I.U.D. DIFFICULTIES	1	
ANEMIA	4	0			
TOTAL	115	25	TOTAL	22	12

TABLE 4: COMPARISON OF REPORTED MAJOR AND MINOR PHYSICAL DIAGNOSES OF SCHIZOPHRENIC AND NEUROTIC PATIENTS

SAMPLE GROUP	REPORTED MAJOR PHYSICAL DIAGNOSIS NO. (%)	REPORTED MINOR PHYSICAL DIAGNOSIS NO. (%)	TOTAL NO. (%)
SCHIZOPHRENICS	115 (83.9)	22 (16.1)	137 (100.0)
NEUROTICS	25 (67.6)	12 (32.4)	37 (100.0)
TOTAL	140	34	174

$X^2 = 5.0419$, D.F. 1, $P < 0.02$

STRATEGIES

1. CLOSER LIAISON WITH:

   MEDICAL CLINICS

   PRIVATE PRACTITIONERS

2. NURSE PRACTITIONER

3. TRAINING NON-MEDICAL THERAPISTS IN BASIC MEDICAL ACTIONS